Larchwood Care Homes (South) Limited

Cameron House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Cameron House is a residential care home providing the regulated activity or accommodation and personal nursing care to up to 44 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 42 people using the service.

People's experience of using this service and what we found
Although there was no impact for people using the service, not all risks to people's safety and wellbeing were assessed, recorded or provided enough detail as to how identified risks should be mitigated. Improvements were required to some aspects of medicines management. Staff, including the management team, did not understand their role and associated responsibilities to protect and keep people safe from harm. People, relatives' and staffs' comments relating to staffing levels at the service were variable, with staffing levels and the deployment of staff not always maintained. However, the latter improved on the second day of inspection and following an additional member of staff being rostered throughout the day.

The provider's arrangements to assess and monitor the service were not effective. Though audits were in place, they needed to be used more effectively, as they failed to pick up the issues identified as part of this inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, where people had bedrails or a sensor mat in place to keep them safe, reasons for this were not recorded to evidence these had been agreed as part of 'best interest' procedures.

People spoken with told us they felt safe and had no concerns about their wellbeing. Suitable arrangements were in place to ensure the service's recruitment practices were safe. The service was clean and odour free. Relatives confirmed there were no restrictions to visiting and that government guidance was being followed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good [published April 2020]

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We undertook a targeted inspection to follow up on specific concerns which we had received about the

service. The inspection was prompted in part due to concerns received about unexplained injuries. A decision was made for us to inspect and examine those risks. We inspected and found there was a concern with staff's moving and handling practices and the service's safeguarding practices and procedures, so we widened the scope of the inspection to become a focused inspection which included the key questions of 'Safe' and 'Well-Led'.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management, safeguarding and the service's governance arrangements.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Cameron House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by one inspector.

Service and service type
Cameron House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cameron House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the Local Authority who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and six people's relatives about their experience of the care provided for them and for their family member. We spoke with six members of staff, the registered manager and regional manager for Cameron House. We reviewed seven people's care files and two staff personnel files. We looked at the provider's arrangements for managing risk, medicines management, staff recruitment and supervision data, complaint and compliment records. We also looked at the service's quality assurance arrangements.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
• Although there was no impact for people using the service, not all risks to people's safety and wellbeing were assessed, recorded or provided enough detail as to how identified risks should be mitigated. This placed people at potential risk of not having risks to their safety met in an appropriate and safe way.
• Where people had a catheter in place, not all risks associated with the catheter had been considered or recorded, for example, bladder spasms, leakage around the catheter, blood or debris in the catheter tube, dehydration and the importance of monitoring people's fluid intake and output. A catheter is a medical device used to empty the bladder and collect urine in a drainage bag.
• Not all people using the service were meeting their daily fluid intake target. The risk of dehydration was not identified, and actions being taken to address this were not routinely recorded.
• Three members of staff were observed on two separate occasions to place their hand under one person's armpit when assisting them to mobilise. This technique is unsafe and can cause injury.
• The provider was not following up-to-date government guidance on how to operate safely during the COVID-19 pandemic. Staff failed to request evidence of the inspector's proof of their rapid lateral flow test.

Using medicines safely
• We looked at the Medication Administration Records [MAR] for eight out of 42 people living at the service. Two people's medication [paracetamol] was not administered as this had run out. This meant both people had not received their prescribed medication in line with the prescriber's instructions.
• Where people were prescribed PRN [when required] medication, not all people using the service had a PRN protocol in place. This provides information about what the medicine is for, symptoms to look out for and when to offer the medicine.
• Where PRN protocols were in place, these lacked the information to support staff to administer the PRN medicine as the prescriber intended.
• Four people's inhalers were not being stored correctly as specified by the manufacturer.

We found no evidence that people had been harmed. However, arrangements were either not in place or robust enough to manage and mitigate risk and improvements were required to the service's medicines management. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. However, where people had bedrails or a sensor mat in place to keep them safe, reasons for the restriction were not recorded to evidence these had been agreed as part of 'best interest' procedures. A 'best interest' assessment determines the person's wishes and whether any restrictions in place are in the person's best interest.

Systems and processes to safeguard people from the risk of abuse
• Although staff had received safeguarding training and were able to tell us about the different types of abuse and describe what actions they would take to protect people from harm and improper treatment, this did not happen in practice.
• Staff did not understand their role and associated responsibilities to protect and keep people safe from harm. Concerns were raised with the Care Quality Commission during the inspection. This related to information being shared with the registered manager, but they failed to consider or raise this as a safeguarding concern with the Local Authority and Care Quality Commission. No investigation was initiated or completed in response to the allegation of harm. We subsequently raised a safeguarding concern with the Local Authority. The above did not provide assurance that effective arrangements were in place to protect people from abuse. Following the inspection, the area manager confirmed the Local Authority was to provide safeguarding training for staff and this included the management team.

Robust arrangements were not in place to safeguard people from abuse. This was a breach of Regulation 13 [Safeguarding] of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People spoken with told us they felt safe and had no concerns about their wellbeing. Comments included, "Yes, I feel safe here [Cameron House]", "I feel very safe" and, "No concerns." Six relatives told us they had no concerns relating to their family member's safety. Comments included, "[Yes, I feel [Relative] is safe", "[Relative] is very safe, definitely" and, "I feel [Relative] is safe and this gives me peace of mind."

Staffing and recruitment
• People and relatives' comments relating to staffing levels at the service were variable. Where these were positive, comments included, "Staffing levels seem fine when I visit" and, "I suppose there are enough staff." Where comments were less positive, these included, "There are occasionally shortages of staff. Yesterday, I was not washed until after breakfast, usually I am washed at 7.30am", "There are definitely not enough staff" and, "[Relative] has had to wait quite a while to have their pad changed and their showers are infrequent. You can sit in the lounge for a long time and you don't see any staff."
• Staff told us there were not always enough numbers of staff available to meet people's needs. One member of staff told us, "I feel rubbish sometimes. Care can be rushed, and task led, personal care can be pushed back." A second member of staff told us, "We can be short staffed sometimes, especially when a member of staff phones in sick at the last minute. We get the work done, but it just takes longer."
• Communal lounge areas were not always staffed while staff assisted people to have their comfort needs

met or to carry out other tasks. This indicated shortfalls in staffing levels at the service. This was discussed with the service's regional manager and following the first day of inspection, an additional member of staff was rostered throughout the day to increase the service's staffing levels. Staff spoken with confirmed this was accurate and this increase was making a difference.
• Appropriate arrangements were in place to ensure the service's recruitment practices were safe. Relevant checks were carried out before a new member of staff started working at the service. This included obtaining written references, ensuring the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS].
• Profiles for agency staff were sought confirming all relevant recruitment checks had been completed by the external agency.

Preventing and controlling infection
• The provider was not following up-to-date government guidance on how to operate safely during the COVID-19 pandemic. Staff failed to request evidence of the inspector's proof of their rapid lateral flow test prior to allowing them to enter the service.
• We were assured the provider was admitting people safely to the service.
• We were assured the provider was using Personal Protective Equipment [PPE] effectively and safely. Staff confirmed there were always enough supplies of PPE available. Observations showed staff wore the correct PPE when supporting people and this was confirmed as accurate by people's relatives.
• We were assured the provider was accessing testing for people using the service and staff. At the time of our inspection there was no COVID-19 outbreak at the service. Staff confirmed they were undertaking COVID-19 testing in line with government guidelines.
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes
• People's relatives were supported to visit the service. We observed visitors with people during our inspection. Relatives confirmed there were no restrictions to visiting and that government guidance was being followed.

Learning lessons when things go wrong
• The registered manager was open and honest about the concerns within the service and acknowledged they had work to do to improve the shortfalls identified and the culture at the service. The latter referred to some people not always experiencing positive outcomes due to poor staff practices and a failure by the registered manager and some senior members of staff to monitor and address issues raised by staff.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The provider's arrangements to assess and monitor the service were not effective. This meant there were missed opportunities to mitigate risks and to make sure people living at the service were safe and received good quality care.
- Though audits were in place, they needed to be used more effectively, as they failed to pick up the issues identified as part of this inspection and recorded within the 'Safe' section of this report. This included the provider's arrangements to ensure risks relating to the quality of the service were identified and recorded, making sure people's medicines were available and stored correctly.
- Effective role models were not able to provide support and guidance to staff to enable them to effectively carry out their roles safely and competently. This referred to the poor moving and handling practices observed during the inspection and safeguarding procedures not being operated effectively by some senior members of staff, immediately upon becoming aware of, any allegation of potential abuse.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Although the registered manager understood the importance of their role, evidence indicated the registered manager did not understand their associated responsibilities in responding to all allegations and concerns about abuse. Where allegations of abuse were investigated internally, not all arrangements were robust. The latter had not been picked up by the provider's own quality assurance arrangements.
- Not all staff felt supported by the provider or the registered manager. Supervision arrangements for staff were not as robust as they should be and only provided information for staff in a range of topics rather than focussing on other aspects, for example, wellbeing. Some staff felt supervision was used to tell them off rather than to provide positive feedback.

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• The registered manager told us they received good support from the provider and received formal supervision.
• People using the service and those acting on their behalf told us they were happy with the care and support received and provided. People's comments included, "The girls are lovely, I am well cared for" and, "The staff are wonderful." Relatives comments included, "The care [Relative] receives is excellent, the staff are so caring. The staff love [Relative] to bits" and, "The care is good, [Relative] is fed well, is always clean and presentable."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Effective arrangements were in place for gathering people's view of the service they received, those of people acting on their behalf and staff employed at the service. The service was still awaiting the provider's report confirming the outcome of the satisfaction questionnaire.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service.
• Relatives comments relating to communication were variable, with both positive and negative comments.

Working in partnership with others
• Information demonstrated the service worked closely with others, for example, the Local Authority, healthcare professionals and services to support care provision.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence that people had been harmed. However, arrangements were either not in place or robust enough to manage and mitigate risk and improvements were required to the service's medicines management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Robust arrangements were not in place to safeguard people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations.